

## *Enough is Enough: Medicare Cuts Threaten Access to Care*

### The Issue

Over the past few years, lawmakers have repeatedly turned to cutting Medicare payments to providers to address budget shortfalls and/or offset the costs associated with implementing new programs, including the expansion of insurance coverage provided by the *Affordable Care Act (ACA)*. **In fact, Medicare payments to Arizona hospitals have been cut by nearly \$3.7 billion over 10 years to address these issues.** As Congress looks for ways to further reduce federal spending, address the debt ceiling, and offset costs associated with fixing the sustainable growth rate, Medicare payments to hospitals remain vulnerable. This prospect is particularly troubling in light of the uncertainty surrounding implementation of the *ACA*, including (1) the delay in employer penalties; (2) uneven Medicaid expansion due to both the U.S. Supreme Court decision that makes expansion voluntary and the future vulnerability of provider assessments, which are being scrutinized by Congress and the Administration; and (3) the narrow network designs that qualified health plans are adopting. Cuts are especially unfair in low cost states like Arizona, which has the fourth lowest hospital expenditures per capita.<sup>1</sup>

### AzHHA's Position

AzHHA strongly opposes additional Medicare payment cuts and the continuation of cuts contained in the *ACA* without the accompanying full implementation of the expanded coverage promised by the *Act*. AzHHA also opposes poorly designed approaches to achieving Medicare savings through arbitrary provider cuts. Instead, we support the development of more rational long-term payment methodologies that reward quality and promote better health outcomes, such as value-based purchasing and accountable care models.

<sup>1</sup>Centers for Medicare & Medicaid Services (2011). *Health Expenditures by State of Residence*. Retrieved (December 2011) at <http://www.cms.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip>.

## Background

Since 2010, Congress and the Centers for Medicare & Medicaid Services (CMS) have enacted a series of Medicare payment cuts for hospital services in their effort to address the federal deficit and offset other program costs, including the cost of expanding insurance coverage under the ACA. These cuts include:

- Various update factors, disproportionate share hospital (DSH) and quality-based payment cuts contained in the ACA;
- Sequestered cuts contained in the *Budget Control Act (BCA) of 2011*;
- Cuts to Medicare bad debt reimbursement contained in the *Middle Class Tax Relief and Job Creation Act of 2012*;
- An inpatient coding cut and outpatient payment cut for stereotactic radiosurgery services contained in the *American Taxpayer Relief Act (ATRA) of 2012*; and
- A separate permanent coding reduction implemented by CMS in 2013.

**These cuts will cost Arizona hospitals \$3.7 billion in lost revenue over the next 10 years—approximately 11.2 percent of our hospitals' total Medicare fee for service revenue.** The chart below provides a breakdown of the existing cuts.

### Existing Legislative Medicare Cuts<sup>1</sup>

ACA Cuts (all provider settings)	(\$2,626,340,400)
Sequestration Cuts (all provider settings)*	(\$527,925,300)
Bad Debt Payment Cuts (all provider settings)	(\$11,131,300)
Coding Adjustment Cuts (inpatient hospital) and Radiosurgery Payment Cut (outpatient hospital)	(\$188,543,600)

### Existing Regulatory Medicare Cuts<sup>2</sup>

Coding Adjustment Cuts (inpatient/home health)	(\$344,796,100)
<b>Total Impact of Existing Cuts</b>	<b>(\$3,698,736,700)</b>

\* The sequestration cuts listed here do not include the \$132 million ten year cost of extending those cuts into 2022 and 2023, as enacted under the Bipartisan Budget Act of 2013.

As Congress continues to deliberate ways to address the debt ceiling, offset the cost of fixing the physician payment formula, and further reduce federal spending, payments for hospital services remain vulnerable. Some of the cuts that have been discussed by Congress and the Administration include:

- Reducing outpatient payments to hospitals for evaluation and management (E/M) services as well as several other ambulatory payment classifications;
- Reducing critical access hospital (CAH) payments by 1 percent and eliminating the sole community hospital (SCH) program;
- Reducing direct and indirect graduate medical education (IME and GME) payments;
- Further reducing bad debt payments;
- Cuts to post-acute care providers, including inpatient rehabilitation facilities and long-term acute care hospitals; and

Lowering the cap on Medicaid provider payments, a payment mechanism that Arizona has recently authorized to fund restoration of the Prop. 204 program and further expand Medicaid.

**If enacted, these cuts would impact Arizona hospitals by more than \$1 billion over the next 10 years<sup>3</sup>:**

Outpatient E/M Cuts (outpatient hospital)	(\$102,861,200)
Indirect Medical Education Cuts (inpatient hospital)	(\$428,936,700)
Direct Medical Education Cuts (inpatient hospital)	(\$76,304,300)
Bad Debt Payment Cuts (all provider settings)	(\$111,552,300)
SCH Program Elimination (inpatient hospital)	(\$360,262,700)
CAH Payment Cuts (inpatient/outpatient hospital)	(\$6,219,700)
<b>Total Impact of Cuts Under Consideration</b>	<b>(\$1,086,136,900)</b>

## Analysis

Hospitals face many challenges in ensuring their patients have timely access to essential medical services. These include:

- Attracting, educating and retaining a high-quality workforce;
- Managing the high cost of technology, equipment, and pharmaceuticals;
- Coping with underpayments from government programs, such as Medicare and Medicaid;

- Providing care for the uninsured and those with multiple chronic diseases; and
- Complying with increasing regulatory and payer requirements.

Despite these challenges, hospitals have pushed forward to improve quality, reduce the cost of care, and proactively redesign the delivery system with an eye to achieving advancements in health outcomes and system efficiencies. These efforts are paying off.

According to the Altarum Institute, the twelve-month moving average for healthcare price inflation was 1.0 percent in August 2013, the lowest rate on record—and even lower than the revised 1.5 percent annual growth rate for 2012 reported by CMS. Low growth in hospital prices is fueling this trend. For August 2013, year-over-year growth in hospital prices was just 1.5 percent, the lowest rate since December 1998. The news for Arizona consumers is particularly compelling. Based on CMS data compiled by the Kaiser Family Foundation, Arizona hospital expenditures per capita rank fourth lowest in the nation.

Hospitals have been able to achieve efficiencies through streamlining diagnostic tests and improving quality, redirecting non-emergency patients to community-based providers, improving case management to reduce readmissions, and enhancing supply side management. Even more savings can be achieved in the future as the system migrates further to value-based purchasing and population health management models.

But the journey to the future is fraught with uncertainties. The ACA's promise of expanded coverage is yet to be determined. The Administration has delayed, for example, the imposition of the employer penalties, and the U.S. Supreme Court has resolved that Medicaid expansion is voluntary. In Arizona, opponents of Medicaid expansion are challenging the enabling legislation. In addition, many of the qualified health plans operating on the Marketplace are shifting financial risk to consumers and providers through the use of high-deductible plans and narrow networks. Within this uncertain environment, Congress is considering further cuts to hospital reimbursement.

### Our Position

Arizona hospitals stand ready to provide care 24 hours a day, seven days a week, ensuring patients have access to the critical medical services they expect. While hospitals will never compromise on quality, the constant ratcheting of funding for hospital services will impact patients' ability to receive the right care at the right time. Cuts will undoubtedly result in longer wait times, fewer doctors and other caregivers, and diminished access to the latest technology and treatments.

**AzHHA urges Arizona's Congressional delegation and federal officials to resist arbitrary cuts to provider payments and focus on real reforms that improve efficiency, reward quality, and target more appropriate utilization of healthcare services.**

Medicare and Medicaid reforms should be based on sound public policy and a vision of transforming care that will reduce costs, increase quality and improve health outcomes of public program beneficiaries as well as the population at large. The focus should not be on arbitrary cuts that can expeditiously generate the most revenue savings. Payment reforms should target healthcare cost-drivers, but reforms should do so in a manner that does not inadvertently shift costs elsewhere in the system.

**With this in mind, AzHHA opposes specious cuts to provider payments, including those that target outpatient evaluation and management services, Medicare bad debt and unsupported coding offsets. Instead, we support real reforms that improve efficiency, reward quality, and target more appropriate utilization of healthcare services, including:**

- **Tying payment to performance through value-based purchasing;**
- **Implementing delivery and payment system reforms that align provider incentives to improve care coordination and quality through accountable care organizations, bundled payments, population health management, and state Medicaid demonstrations;**
- **Addressing overutilization of healthcare services through income appropriate cost-sharing reforms; and**
- **Enacting common sense medical liability reforms.**

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**Data Notes:**

**(1) Existing Legislative Medicare Cuts Include:**

- ACA Cuts: The impact shown reflects the ACA-authorized hospital/health system payment cuts and includes: update factor cuts (all-provider settings); payment cuts and changes related to the mandatory quality-based payment reforms of value-based purchasing, the readmissions reduction program, and the hospital-acquired conditions payment policy (inpatient hospitals); and Medicare disproportionate share hospital (DSH) payment cuts (inpatient hospitals). The impact shown does not capture ACA update factor cuts implemented prior to 2013 that carry forward additional negative impacts in the budget window analyzed.

- Sequestration Cuts: The impact shown reflects the BCA-authorized 2.0 percent sequester reduction on total Medicare payments for a nine-year period (2013-2021 - the two-month delay in sequestration cuts legislated under the ATRA is accounted for in this analysis). CMS had not released guidance on how sequestration would be implemented at the time of this analysis. It was assumed that the 2.0 percent adjustment would be applied to all Medicare lines of payment, including those outside of the PPS rate and not included in this impact estimate, i.e., Direct Graduate Medical Education. Payments to Medicare Advantage plans will also be reduced, but the potential effect on providers will depend on the terms of each individual contract.

- Bad Debt Payment Cuts: The impact shown reflects the Middle Class Tax Relief and Job Creation Act of 2012-authorized reduction to Medicare payments for reimbursable bad debts for all provider settings to 65 percent.

- Coding Adjustment Cuts and Radiosurgery Payment Cut: The impact shown reflects the ATRA-authorized retrospective (one-time) coding adjustment cuts totaling at least -9.7 percent that CMS must implement over a four-year period (FFY 2014-2017). The impact of the ATRA provision that reduces the outpatient payment amount for certain stereotactic radiosurgery services beginning April 1, 2013 and thereafter is also shown.

### **(2) Existing Regulatory Medicare Cuts Include:**

- Coding Adjustment Cuts: The impact shown reflects the CMS-imposed prospective (permanent) coding adjustment cuts of 1.9 percent (0.5 percent for hospitals paid at the hospital-specific rate) in 2013 (inpatient hospitals) and a 1.32 percent in 2013 (home health providers). The impact shown does not capture CMS coding adjustment cuts implemented prior to 2013 that carry forward additional negative impacts in the budget window analyzed.

### **(3) Additional Medicare Cuts Under Consideration Include (this analysis excludes cost of proposed post-acute care cuts):**

- Outpatient E/M Cuts (source: H.R. 3630): The impact shown reflects the U.S. House-approved policy from 2011 to cap payment to hospitals for outpatient evaluation and management services at the payment level provided to physicians under the Medicare physician fee schedule. Due to data limitations, impacts for flat rate and specialty hospitals subject to this cut are not shown in this analysis.

- IME Cuts (source: Simpson-Bowles Commission): The impact shown reflects the recommendation to cut inpatient Indirect Medical Education payments in half by reducing the IME reimbursement percentage of 5.47 percent to 2.2 percent.

- GME Cuts (source: Simpson-Bowles Commission): The impact shown reflects the recommendation to limit teaching hospital's Direct Graduate Medical Education reimbursement to 120 percent of the national average salary paid to residents in 2010, updated annually thereafter.

- Bad Debt Payment Cuts (source: Simpson-Bowles Commission): The impact shown reflects the recommendation to eliminate payment for reimbursable bad debts for all provider settings.

- SCH Program Elimination (source: Congressional Budget Office): The impact shown reflects the recommendation to eliminate special inpatient payment status for sole community hospitals.

- CAH Payment Cuts (source: Congressional Budget Office): The impact shown reflects a reduction in reasonable cost-based reimbursement to critical access hospitals from 101 percent to 100 percent for inpatient, outpatient, and swing-bed services.